THE RECOVERY KERNEL

How to Navigate the Recovery Kernel

For People Recovering from 7-OH

7-hydroxymitragynine products: tablets, gummies, shots, extracts, and isolates. A step-by-step route: what to read, in what order, and what outcome the Kernel projects if you follow it.

> **HARM REDUCTION RESOURCE — NOT MEDICAL ADVICE.** The Kernel places extracts and 7-OH isolates at the far end of the kratom family: near the pure opioid profile, with the highest dependence risk, the highest overdose risk, and the most severe withdrawal. Severe sedation, difficulty waking, or slowed breathing is an emergency: call 911, give naloxone if you have it, and stay with the person. The Kernel notes naloxone may only partly cover kratom-family toxicity, so it is a supplement to 911, not a substitute.
>
> Withdrawal is opioid-type, and **buprenorphine can manage it: ask for it by name.** 7-OH and mitragynine are not reliably detected on standard opioid urine screens, so tell emergency staff the specific substance.
>
> Crisis: call or text 988 · SAMHSA: 1-800-662-4357 · Never Use Alone: 1-800-484-3731

1. Before you start

This is a route through the Recovery Kernel for people whose problem is 7-OH products, and for the people supporting them. The Kernel's chapter on kratom (Supplemental Ch. 20) covers the whole family, and it says that because the dependence is mediated through the mu-opioid receptor, the same medication-assisted treatment framework as opioid use disorder applies. This guide therefore runs on that opioid framework (Supp. Ch. 18 and 35), with the kratom-specific points from Chapter 20 layered on. Six rules set the order of everything that follows.

- **Treat it as opioid use disorder.** MAT is a foundation, not a compromise. Extended buprenorphine treatment is associated with better outcomes than short courses, and the Kernel says the underlying receptor dependence may warrant sustained MAT.
- **Survival before biology.** Naloxone, never using alone, and respect for lost tolerance come first (Supp. Ch. 18 §0). The highest-risk period is a return to a prior dose after any break.
- **Induction needs care.** 7-OH binds the mu receptor with high affinity, so buprenorphine started before enough clearance can precipitate withdrawal. Prescribers use low-dose (microdosing) inductions to avoid this. Let your prescriber manage it.
- **Check every medication for CYP3A4 interactions.** Some drugs can dramatically raise the effective opioid-like dose, and others can precipitate withdrawal.
- **Plan for a moving supply.** Legal changes can cut off products with little warning. A sudden loss should not become unplanned cold turkey or a street opioid.

- **Do not wait for test results to start.** The genome refines the plan (Main Book, Quick-Start Step 3; Supp. Ch. 5, Step 1b).

How chapters are cited. "Main Book" is the Recovery Kernel Main Book (Second Edition, Centurian). "Compendium" is the Complete Protocol Compendium. "Supp. Ch. N" is chapter N of the Supplemental Book. The core chapters are Chapter 20 (How to Recover from Kratom), Chapter 18 (How to Recover from Opioids), and Chapter 35 (Discontinuance Protocol: Opioids). Chapter 19 (Fentanyl) is the Kernel's guide for the most potent agonists. The provided files contain 7-OH only inside Chapter 20 and a few cross-references; there is no standalone 7-OH chapter, so this guide is built from those.

> **Legal status is changing fast, so check it.** The Kernel's regulatory section (Supp. Ch. 20 §8) predates recent federal action. In July 2026 the DEA filed notices of intent to temporarily place 7-OH above a set concentration, and three synthetic 7-OH derivatives, in Schedule I. Secondary reports say the three derivatives were scheduled effective August 26, 2026, and that the 7-OH threshold order had not been reported as published as of early September. Federal health agencies said the action is not aimed at natural leaf kratom below the threshold, but some states go further than the federal action, and the Kernel lists six states that already ban kratom (Alabama, Arkansas, Indiana, Rhode Island, Vermont, Wisconsin). Verify in the Federal Register and your state's law. If your supply could be cut off, talk to a MAT prescriber now, before you run out, so that a sudden loss of product does not push you into unplanned withdrawal or a street opioid.

> **A note on protocol numbers.** The opioid and kratom chapters cite Compendium protocols by number, and some numbers do not match the Compendium as printed. They call Protocol 05 "environmental redesign" (printed: Digital Detox), Protocol 03 "exercise" (printed: Sonic Architecture; exercise is Protocol 19), Protocol 12 "music" (printed: Hydration Science; music is Protocol 03), Protocol 16 "family and relationship repair" (printed: The Isolation Spiral), and Protocol 20 an identity protocol (printed: Mapping the Terrain). Chapter 20 also refers to a "C-37 principle" (the Compendium prints Protocol 37, Substance Masking Analysis) and sends a pain-plan reference to "Section 3" (the pain material is in Section 6). This guide cites each protocol by its printed title. If a number and a title disagree, follow the title.
>
> For 7-OH, watch for increasing the amount or frequency to chase a fading effect across different batches — potency varies by product, so a fading effect is not a reliable signal to escalate.
>
> Redosing is not the only version of this. Watching peers in a treatment setting negotiate a relapse, getting confident advice from someone untrained in your specific situation, or noticing a prescriber treat a prescribed substance more casually than an illicit one can all trigger the same pattern: a felt doubt read as “the plan must be wrong,” answered by abandoning it. See **The Commandeering Map**, a companion to this series, for the fuller pattern, including how it can differ by genetic profile and what helps when practice-based resistance alone is not enough.

2. The route at a glance

Steps 0 and 1 come first. Steps 2 to 4 can run at the same time. Steps 5 to 9 overlap and are the work of the first two years. Step 10 is everything after. "P" means Compendium Protocol; "C" means Centurian Paper.

Step	When	What you do	Turn to
0	Day 0	Triage: overdose signs, naloxone, medication interactions, what the product really contained.	Supp. Ch. 20 §0 Supp. Ch. 18 §0; Ch. 35 §0 Main Book, Quick-Start Step 1
1	Days 0–14	Buprenorphine with careful induction, or supervised withdrawal. Clonidine and comfort meds.	Supp. Ch. 20 §3, §4.5 Supp. Ch. 18 §3; Ch. 35 §§1–3, 7–8 Supp. Ch. 38
2	Weeks 1–4	Read the Main Book in order.	Main Book: Who This Book Is For, Quick-Start, Part One (Ch. 1–5) Supp. Ch. 2, 3
3	Weeks 1–4	Order 30× whole-genome sequencing. Add a clinical PGx panel and baseline labs.	Supp. Ch. 5 Step 1 Supp. Ch. 20 §2; Ch. 18 §2 Compendium P06
4	Weeks 2–6	Resolve your profile. Work out why you started.	Supp. Ch. 5 Steps 2–3, 6 Supp. Ch. 20 §§1.3, 2 Supp. Ch. 35 §5
5	Day 1 to Month 6	Build the biological foundation with your prescriber and pharmacist.	Supp. Ch. 20 §4 Supp. Ch. 18 §4 Compendium P17, P18, P09, P07
6	Weeks 2–12, then ongoing	All product out. Craving types. Supply and cue redesign.	Supp. Ch. 20 §5 Supp. Ch. 18 §5 Compendium P20, P21, P08, P33, P05
7	Months 1–24	Rebuild the endorphin system: exercise, touch, laughter, service.	Supp. Ch. 20 §6 Supp. Ch. 18 §6; Ch. 36; Ch. 3 Compendium P19, P03, P29
8	In parallel	Pain, mood, and long-term medication. Trauma work when stable.	Supp. Ch. 20 §§3, 7 Supp. Ch. 18 §§4.3, 8 Compendium P14, P13; Supp. Ch. 39
9	Months 2–12+	Identity, inventory, amends, money, work, family.	Supp. Ch. 42, 43, 51 Compendium C-28, P23, P24, P22
10	Year 1 to Year 10	Steward: review, transplant, mentor.	Supp. Ch. 44, 6, 38 Compendium P02, P13 Supp. Ch. 5 Step 6

3. The route, step by step

Step 0 — Triage (Day 0, before everything)

Get naloxone and keep it where others can find it. Know the overdose signs: severe sedation, difficulty waking, slowed or stopped breathing, blue or gray lips. Do not use alone. If you have had any stretch of abstinence, whether from treatment, a hospital stay, or simply running out, your tolerance is gone and a prior dose can kill you. The Kernel identifies that as the most common way opioid recovery ends in death. If an overdose looks more severe than expected, assume the product may have been contaminated: fentanyl adulteration of kratom-family products is rare but documented.

Two further cautions from the Kernel. Mitragynine, which many 7-OH products also contain, has documented heart-rhythm (QTc) effects, so palpitations, a racing heart, fainting, or dizziness call for an ECG, and you should disclose the specific substance. And kratom-family products have been documented to cause drug-induced liver injury, so yellow skin or eyes, dark urine, severe abdominal pain, or extreme fatigue means stopping and seeking emergency evaluation. Because 7-OH products are unstandardized and sold in many forms, what is in yours may differ from the label.

Turn to: Supp. Ch. 20 §0 (high-dose overdose; QTc; liver injury; contamination). Supp. Ch. 18 §0 and Supp. Ch. 35 §0 (naloxone; overdose recognition; the tolerance rule). Main Book, Quick-Start Boot Sequence, Step 1. Compendium Protocol 01, Emergency Triage, for an acute crisis state.

Step 1 — Medical stabilization and MAT (Days 0–14)

Find a prescriber. Any DEA-registered provider can prescribe buprenorphine, and the Kernel gives you the wording: tell them you are dependent on a kratom-family product that acts as a partial mu-opioid agonist, that buprenorphine has been used for kratom withdrawal, and that you are requesting evaluation for buprenorphine-assisted management. Buprenorphine is the first-line option. Extended-release naltrexone is an option only after complete clearance (typically 7 to 10 days abstinent), because it precipitates severe withdrawal if any opioid remains, and OPRM1 G carriers respond best. Clonidine helps the autonomic symptoms, and the comfort medications in Supp. Ch. 18 §3.2 apply. The Kernel notes the evidence for buprenorphine in kratom-family withdrawal comes from multiple case reports and clinical series, not large trials, while the broader opioid MAT evidence is strong.

The timeline: onset 12 to 24 hours after the last use; peak at 24 to 72 hours, with body aches, insomnia, anxiety, GI symptoms, depression, and intense craving; then days 3 to 7 with prominent depression; then weeks 2 to 12 of episodic post-acute symptoms. The Kernel says 7-OH isolates sit at the severe end. The main danger is not the withdrawal but returning to a prior dose at zero tolerance, which is why MAT sits at the center.

Turn to: Supp. Ch. 20 §3 (MAT for kratom: buprenorphine, naltrexone, clonidine; the physician conversation) and §4.5 (withdrawal timeline). Supp. Ch. 18 §3 (detox, withdrawal, and MAT). Supp. Ch. 35 §§1–3 and 7–8 (why the guide centers on MAT; timeline; use-pattern classification; MAT and detox). Supp. Ch. 38 (questions to ask about MAT duration).

Step 2 — Read the Main Book (Weeks 1–4, alongside Step 1)

Read it in order once you are physically stable. If you are overwhelmed, the Quick-Start Boot Sequence is designed to be read on its own. Read "Who This Book Is — and Is Not — For" first: it names situations where the supplement protocols need medical modification, including active psychosis, pregnancy, and severe liver disease, which matters here because of the liver-injury risk.

Read in this order: Who This Book Is For → Quick-Start Boot Sequence → Part One: Ch. 1 (Why Willpower Isn't Enough), Ch. 2 (MTHFR), Ch. 3 (COMT), Ch. 4 (CYP450, the drug-interaction chapter), Ch. 5 (When Systems Collide) → Ch. 7 (Harm Reduction), only if you are still using → Part Two, the case files (Chapter 6), especially the Philip Seymour Hoffman file, which is the tolerance-reset lesson. Ch. 8 (Oxytocin Protocol) is experimental and specialist-only. Ch. 9 (Epigenetic Playground) belongs to Steps 7 and 10. Appendix A and Appendix B are reference.

Then add: Supp. Ch. 2 (Clarity · Restoration · Manning). The Kernel has no 7-OH case study, but Case 14 (kratom), Case 03, and Case 08 (opioid MAT) are the nearest profiles. Supp. Ch. 3 (The Addict Virgin Problem) recalibrates timelines for a damaged system. Supp. Ch. 1 (Why They Left You There) is optional reading for the shame.

Step 3 — Get your DNA (Weeks 1–4)

The Kernel's recommended route is 30× whole-genome sequencing, which returns a VCF file, a one-time asset you keep. A consumer SNP array is an acceptable start. A clinical pharmacogenomic panel adds clinical-grade CYP2D6 and CYP3A4 calls. Homocysteine, B12, and RBC folate are functional markers you can recheck quarterly.

For this family, the Kernel names **CYP3A4** as the most clinically important gene: it converts mitragynine to 7-OH and clears it, and it governs how buprenorphine and methadone behave. Next come **OPRM1** (the same gene as in the opioid guides, and the predictor of naltrexone response), **CYP2D6** (a secondary pathway, and a prodrug-opioid safety marker), **COMT**, and **MTHFR**. From the opioid panel add DRD2/ANKK1, BDNF, and ABCB1. Ask any prescriber to review interactions before writing a new prescription. Until results arrive: did the product feel far stronger than expected at amounts others tolerated; did its strength change suddenly after a new medication; did you use it for pain, for opioid withdrawal, or for energy?

> **Confirm what you are ordering.** Supp. Ch. 5 specifies 30× whole-genome sequencing with VCF output. "WGBS" more commonly names whole-genome bisulfite sequencing, a DNA-methylation assay that is not built to call variants such as MTHFR C677T. Ask the lab for a standard variant file (VCF).

Turn to: Supp. Ch. 5, Step 1. Supp. Ch. 20 §2 (genomic blueprint; phenotyping without testing). Supp. Ch. 18 §2 (the opioid DNA panel). Compendium Protocol 06, Phenotype Assessment. Main Book Ch. 2 and Ch. 3 self-assessments.

Step 4 — Resolve your profile (Weeks 2–6)

The Kernel finds three reasons people arrived at kratom-family products, and each changes the plan. Opioid replacement or self-managed withdrawal: stabilize this dependency first, then address the underlying opioid history, and treat the original driver (pain, trauma, PTSD). Chronic pain: pain management is a concurrent clinical target, and stopping without a pain plan fails. Energy, focus, and function: the stimulant-recovery architecture applies alongside the opioid framework, with an ADHD evaluation if the stimulant effect was the draw. Write your profile down and carry key results on a card.

If your result is...	What changes	Source
CYP3A4 inhibitors	Grapefruit, fluconazole, clarithromycin, many HIV antiretrovirals, and some antidepressants can dramatically raise the opioid-like effect by slowing clearance. They also affect buprenorphine and methadone levels. Tell every prescriber everything you take.	Supp. Ch. 20 §§1.2, 2; Ch. 35 §5
CYP3A4 inducers	Rifampin, St. John's wort, and carbamazepine accelerate clearance and can precipitate withdrawal at a previously adequate amount, or clear MAT faster.	Supp. Ch. 20 §2; Ch. 18 §2
OPRM1 A118G (G carrier)	Needed higher amounts for the same effect. Stronger naltrexone response after 7–10 days of clearance. Raise with your prescriber.	Supp. Ch. 20 §§2, 3.2; Ch. 35 §5
CYP2D6 poor or ultrarapid	A secondary pathway for kratom alkaloids. Poor metabolizers get little from codeine or tramadol; ultrarapid metabolizers can convert codeine to morphine dangerously fast. Carry the result.	Supp. Ch. 20 §2; Ch. 35 §5
COMT Val/Val (Warrior)	Drawn to the stimulant-like profile at lower amounts. Recovery needs stimulation and mastery alongside the endorphin rebuild.	Supp. Ch. 20 §2
COMT Met/Met (Sage)	The more common opioid-recovery profile: the relief was the first time a hot nervous system got to stand down.	Supp. Ch. 35 §5
MTHFR variants	5-MTHF often produces meaningful early improvement in mood and energy. Avoid synthetic folic acid with any T variant.	Supp. Ch. 20 §4.1; Main Book Ch. 2
DRD2 A1, BDNF Met	Fewer D2 receptors: build several reward sources. Reduced BDNF: exercise is the primary repair driver.	Supp. Ch. 18 §2

Turn to: Supp. Ch. 5, Steps 2, 3, and 6 (gene systems, combined profiles, profile template). Supp. Ch. 20 §§1.3 and 2. Supp. Ch. 35 §5. Main Book Ch. 5 and Appendix A.

Step 5 — Build the biological foundation (Day 1 to Month 6)

The foundation combines the opioid recovery framework with kratom-specific liver support. Layers: methylation support; endorphin-system support (DLPA, NAC, omega-3, vitamin D with K2); dopamine reconstruction if you were in the stimulant profile; liver protection, since liver function testing (AST, ALT, GGT, bilirubin) is recommended for all significant histories and alcohol should stop while enzymes are elevated; sleep repair, because the opioid system is central to sleep architecture; and a peptide layer. The dose tables are in the chapters below. Run every addition past a pharmacist and an interaction checker (Drugs.com or Medscape), especially given CYP3A4. The peptide layer in Supp. Ch. 20 §4.7 is not a self-start step.

Turn to: Supp. Ch. 20 §4.1 (methylation), §4.2 (endorphin reconstruction), §4.3 (dopamine, for the stimulant profile), §4.4 (liver support), §4.6 (sleep), §4.7 (peptides). Supp. Ch. 18 §4. Supp. Ch. 5, Phase One. Main Book Ch. 2, §2.4–2.5. Compendium Protocol 17 (The Nightly Restoration), Protocol 18 (Eating for Restoration), Protocol 09 (The Gut-Brain Axis), Protocol 07 (Neuroplasticity), and Centurian Paper C-32 (The Insomnia Architecture).

Step 6 — Supply, cues, and cravings (Weeks 2–12, then ongoing)

The Kernel names four trigger types for this family: physical pain (a pharmacologically rational craving, because the product was managing real pain), fatigue and morning demand (for the energy profile), the product being visible or accessible, and post-acute episodes that feel like withdrawal. The single most reliable step is environmental: remove all product from the home, car, and workspace, completely, and do not "keep it just in case." Name a PAWS episode for what it is ("this is a post-acute episode, not withdrawal; I have not used; this will pass"), and log each episode, because three weeks of records reveal the pattern.

Add the opioid framework's warnings: cue-triggered craving is a conditioned reflex, not weakness. Know the highest-risk situations before they arrive: return of tolerance, pain events, grief, celebration, and a gap in MAT supply. Have backup plans so that a legal change, a missed appointment, or a pharmacy problem never becomes a gap.

Turn to: Supp. Ch. 20 §5 (the dual craving; triggers; the 5-minute interrupt). Supp. Ch. 18 §5 (the opioid craving interrupt; highest-risk situations). Compendium Protocol 20 (Mapping the Terrain), Protocol 21 (Reading the Collapse), Protocol 08 (Social Environment), Protocol 33 (The Boundary Architect), Protocol 05 (Digital Detox).

Step 7 — Rebuild the endorphin system (Months 1–24)

For the opioid-profile user, the Kernel's natural architecture is endorphin-centered: vigorous sustained exercise (the primary activator, and non-optional), genuine human connection and safe touch, cold exposure, and service. For the stimulant-profile user, add the dopamine architecture: high-intensity exercise with a competitive element, mastery at the skill frontier, and ADHD treatment if indicated. Because receptors take months to recover, everything hurts more and feels flatter at first. That is the biology, not failure. Expect timelines two to three times longer than the standard literature for a damaged system.

Turn to: Supp. Ch. 20 §6 (natural architecture for two pharmacological profiles). Supp. Ch. 18 §6 (endorphin architecture; social reconnection). Supp. Ch. 36 (Roots and Reversal). Supp. Ch. 3 (timeline recalibration). Compendium Protocol 19 (The Body in Motion), Protocol 03 (Sonic Architecture), Protocol 29 (The Peacetime Paradox).

Step 8 — Pain, mood, and long-term medication (in parallel)

If pain was part of why you started, the Kernel is direct: stopping without a concurrent pain plan will fail, and the pain track runs alongside recovery indefinitely. Buprenorphine is itself an analgesic, so it can address pain and the dependency together. Other tools: physical therapy, exercise-induced analgesia, mindfulness-based pain reduction, acupuncture, TENS, heat and cold, and sleep optimization. The Kernel also describes low-dose naltrexone by prescription as an option that may help if chronic pain drove use; this is a prescriber decision. Treat depression, anxiety, and trauma as their own conditions, with trauma work after biological and MAT stability.

Turn to: Supp. Ch. 20 §3 (MAT), §6 (pain management: the third natural architecture), and §7 (the protocol map; the pain management track). Supp. Ch. 18 §4.3 and §8 (pain and co-occurring conditions). Supp. Ch. 38. Compendium Protocol 14 (Pain Management), Protocol 13 (The Pharma Trap). Supp. Ch. 39 (Complex Trauma and the Substance Connection).

Step 9 — Identity and rebuilding a life (Months 2–12+, revisited later)

The Kernel's compassion for this group is specific: many arrived by doing harm reduction imperfectly with what was available, to escape prescription opioids or manage pain a system had undertreated. The signal was accurate, and the solution developed its own problem. Full Inventory is a structured 180-day plan, and Amends to Self puts the person who lived through it first. Family, money, and work follow.

Turn to: Supp. Ch. 42 (Full Inventory). Supp. Ch. 43 (Amends to Self). Centurian Paper C-28 (The Recast). Compendium Protocol 23 (Rebuilding the Ledger), Protocol 24 (Returning to Work), Protocol 22 (The Family Field), Protocol 16 (The Isolation Spiral), Protocol 25 (The Open Door). Supp. Ch. 51 (Family & Support Network Guide): give it to the people who love you.

Step 10 — The long game (Year 1 to Year 10)

The Kernel maps the first 24 months of opioid-framework recovery in detail. After that, navigation shifts from repair to stewardship. Section 4 shows how. Standing tools: Supp. Ch. 44 (The Transplant: redirect the devotion and daily structure the pattern required into a practice that grows). Supp. Ch. 6 (Stay Non-Addicted) and Compendium Protocol 02 (Behavioral Addictions, with its "Mask Change" caution on addiction transfer). Compendium Protocol 13 (The Pharma Trap, a regular review of whether each medication is still needed). Supp. Ch. 38. Supp. Ch. 5, Step 6 (a weekly AI check-in profile, a reasoning tool and never a provider).

4. How navigation changes at Years 3, 5, and 10

Shading shows how much attention each track needs. Darkest is primary focus, then active, then maintenance. White cells with gray text are standing safeguards: low effort, never dropped. Numbers in brackets refer to the shifts listed below the table.

Track	Months 0–24 (foundation)	Year 3 (consolidate)	Year 5 (build out)	Year 10 (steward)
Safety and medication	Naloxone; MAT; safe induction	MAT review, not autopilot [1]	Naloxone kept; pain-event plan	Tolerance-reset rule, for life [7]
Biology and genome	CYP3A4, OPRM1; methylation base	Retest labs; step stack to upkeep [2]	Prescriber card: CYP3A4, OPRM1	Re-check with new meds and age
Access and supply	All product out; supply plan	Cues fainter, not gone	Triggers: pain, grief, wins [5]	Same plan, rehearsed
Endorphin and reward	Exercise, touch, laughter, music	Natural reward carries the load [3]	Exercise is a lifestyle	Periodized, still daily
Pain and mood	Pain track first; trauma later	Trauma work, if stabilized	Pain plan, annual review	New pain: age, surgery, dental [8]
Identity and inventory	Full inventory; identity from month 2	Amends to self; recast the self	Identity beyond the using years	Annual re-inventory
Meaning and Manning	Purpose: first seeds only	Transplant; return to work [4]	Manning: mentor, service [6]	Mentor or run a group

The eight shifts

1. **Year 3, MAT becomes a review, not autopilot.** The Kernel treats medication as scaffolding with exit criteria but carves MAT out: someone stable on it is in genuine recovery, and sustained treatment may be warranted. Bring the duration and readiness questions in Supp. Ch. 38 to your prescriber. Compendium Protocol 13 gives the review standard.
2. **Year 3, the stack moves from building to testing.** Retest labs, including liver function, and step down toward maintenance. The Trinity chapter says supplements are taken until stable, then tapered and resumed if the system destabilizes; Main Book Ch. 2 treats MTHFR support as maintenance, not cure. Step down to maintenance, not to zero.
3. **Year 3, natural reward carries the load.** The opioid framework places substantial receptor and endorphin recovery at 12 to 18 months (Supp. Ch. 18 §3.3). Exercise, connection, and laughter stop being a bridge across a deficit and become ordinary life.
4. **Year 3, meaning moves up.** As the repair tracks drop to maintenance, redirect the devotion and daily structure the pattern required into a practice (Supp. Ch. 44) and return to work (Compendium Protocol 24).
5. **Year 5, triggers shift from cues to life events.** As cue-driven craving fades, the Kernel's named exposures remain: pain events, grief, celebration, and any gap

in MAT supply (Supp. Ch. 18 §5). A change in the legal status of products or supply is a new kind of trigger to plan for.

6. **Year 5, Manning.** This is the Trinity's third stage (Supp. Ch. 2). Supp. Ch. 18 §6 says many long-term opioid recovery successes name service as the central pillar, so mentoring and peer support peak here.
7. **Year 10, the tolerance-reset rule stays for life.** The Hoffman case file (23 years sober, dead at 46) is the Kernel's own argument that risk never reaches zero. Naloxone in the home and a written relapse plan are permanent. This guide applies the opioid rule to 7-OH because the Kernel says the opioid framework applies.
8. **Year 10, new pain.** Age brings surgeries, dental work, and new pain, which the Kernel names as relapse triggers (Supp. Ch. 18 §5, §4.3). Make the plan before the event, and give every prescriber your genotype, your history, and the specific substance.

What is sourced and what is extrapolated. *Shifts 3, 6, and 7 rest directly on Kernel opioid text applied to this family. Shifts 1 and 2 apply Kernel rules at a timing chosen for this guide. Shifts 4, 5, and 8 are extrapolations. The Kernel has no 7-OH-specific timeline beyond withdrawal and PAWS, and its detailed opioid timeline ends near month 24, so years 3, 5, and 10 are projections.*

5. What outcome to expect

The short version

If you do the route above, with naloxone and MAT first, careful induction, genome-guided medication choices, the biological foundation, all product out and the supply handled, the endorphin rebuild, pain and mood treated in parallel, and then identity and purpose work, this is the outcome the Kernel's framework projects:

- **You survive the early window.** Withdrawal is managed with buprenorphine or supervised care, you do not return to a prior dose at zero tolerance, and naloxone is always within reach.
- **Within 12 to 18 months the systems the product occupied come back online.** Receptors, the endorphin system, the dopamine baseline, sleep, and pain sensitivity recover. Post-acute episodes thin out, and can last up to about 18 to 24 months in the opioid framework.
- **MAT, if you choose it, is part of recovery, not a detour.** Extended buprenorphine is associated with better outcomes, and the Kernel says the receptor dependence may warrant sustained treatment.
- **By years 3 to 5 the work is maintenance and building. By year 10 you are a steward,** carrying a small set of standing safeguards.

The Kernel does not promise zero risk. It states that the highest-risk moment is a return to a prior dose after a break, that products in this family are unstandardized, and that the legal and supply picture can change under you.

Milestones, in order

Milestone	When	Expected outcome	Source	Basis
Survive the early window	Days 0–14	Naloxone on hand. MAT initiated with careful induction, or supervised withdrawal. No unsupervised return to a prior dose.	Supp. Ch. 20 §§0, 3; Ch. 18 §3	Clinical fact
Acute withdrawal	Onset 12–24 h; peak 24–72 h; days 3–7	Body aches, insomnia, anxiety, GI symptoms, depression, intense craving. The Kernel places isolates at the severe end.	Supp. Ch. 20 §§1.1, 4.5	Clinical timeline
Post-acute episodes	Weeks 2–12	Episodic dysphoria, anxiety, sleep disruption, craving: good days, then bad days without a trigger. Not relapse.	Supp. Ch. 20 §4.5	Kernel projection
Liver and heart checks	Early, then as advised	Liver enzymes assessed; ECG if palpitations. Kratom-family liver injury usually presents 1–8 weeks after starting or escalating; some resolves with cessation.	Supp. Ch. 20 §§0.2–0.3, 4.4	Kernel projection
Receptor and endorphin recovery	Months 6–18+	Mu-opioid receptor density substantially recovered; natural comfort and social bonding return. (Opioid framework.)	Supp. Ch. 18 §3.3	Kernel projection
PAWS window	Up to 18–24 months	Waves of anxiety, flatness, or unexplained craving become rare. (Opioid framework.)	Supp. Ch. 18 §3.4	Kernel projection
Deep-root reversal	2–5+ years	Prefrontal recovery and epigenetic reversal continue. Some changes may be partial.	Supp. Ch. 36	Kernel projection
Steward phase	Years 3–10	Repair tracks at maintenance. MAT reviewed. Purpose and service. Standing safeguards.	Section 4 of this guide	Extrapolated

The Kernel's 12-month numbers: nearest analogs only

The Kernel has no 7-OH-specific projection. Case 14 (kratom) is the nearest substance profile: a 37-year-old with fibromyalgia and chronic pain, CYP2D6 intermediate, using six to eight times a day to prevent withdrawal. The Kernel's own summary is that the outcome depends on whether the pain can be adequately managed through an identified alternative. Case 03 is the nearest opioid MAT profile. Treat both as analogs, not predictions for a concentrated 7-OH product.

Case	Measure	Kernel protocol	Standard treatment
Case 14	Dose reduction of 50% or more at 12 months with pain management in place	65%	20%
Case 14	Pain management maintained through non-kratom means	60%	15%
Case 14	Avoidance of escalation to unregulated opioids	78%	50%

Case	Measure	Kernel protocol	Standard treatment
Case 03	12-month MAT retention with OPRM1-guided medication selection	74%	40%
Case 03	No overdose events at 12 months, with naloxone access	82%	55%

How to read these numbers. *The Kernel describes them as archetype projections, "probability estimates" for an adherent, biologically confirmed 12-month protocol. They are not guarantees, and the Main Book states that it is not reporting a randomized controlled trial of the Kernel itself. For Case 14 the Kernel itself notes that standard kratom-dependence outcome data is limited.*

What changes the outcome

- **Skipping Steps 0 and 1.** No supplement or genome result compensates for a return to a prior dose at zero tolerance.
- **Starting buprenorphine too soon after use without a plan.** It can precipitate withdrawal. Let your prescriber choose the induction approach.
- **Running out of MAT,** or a legal or supply change forcing a sudden stop. Plan continuity.
- **An unrecognized drug interaction.** CYP3A4 inhibitors can raise the effect dramatically, and inducers can precipitate withdrawal.
- **Untreated pain or trauma.** The Kernel names both as the most reliable paths back.
- **Keeping product "just in case."** Environmental removal is more reliable than resistance.
- **Alcohol while liver enzymes are elevated,** and ignoring jaundice, dark urine, or severe abdominal pain.
- **A lapse.** The Kernel treats it as information, not judgment (Protocol 21). It is also an overdose-risk event: keep naloxone, contact your MAT provider, and do not use alone.

How to read the evidence behind the outcomes

The Main Book marks claims with an Evidence Tier: Established, Probable, Emerging, Author/System Experience, and Controversial or Mixed. This guide's reading: the mortality benefit of MAT for opioid use disorder and the danger of lost tolerance are well-established. Applying them to 7-OH follows the Kernel's reasoning from the shared receptor mechanism, and the Kernel's evidence for buprenorphine in kratom-family withdrawal is case reports and series. The supplement stack, the low-dose naltrexone note, the peptide layer, the percentage analogs, and the years 3 to 10 trajectory sit lower on that scale, so bring them to your clinician as questions, not as facts.

Take these to your prescriber

- The specific product and form you used, how much and how often, and any other substances, so induction can be timed and the record is accurate.
- Every medication and supplement you take, so CYP3A4 interactions can be checked, plus your CYP3A4, OPRM1, and CYP2D6 results.
- A written MAT plan: target duration, readiness markers for any taper, and how supply continuity is guaranteed.
- A request for liver function tests and, if you had palpitations or take QT-prolonging drugs, an ECG.
- A pain plan made before any surgery or dental procedure, and naloxone for you and everyone in your home.